LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV
MEETING MINUTES
February 13, 2014

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS PRESENT *(cont.)*	DHSP STAFF
Michael Johnson, Esq., *Co-Chair*/ Kevin Donnelly	AJ King, MPH	Shoshanna Scholar	Kyle Baker
	Lee Kochems, MA	Terry Smith, MPA	Angela Boger
Ricky Rosales, *Co-Chair*	Mitchell Kushner, MPH, MD	Jason Tran/Rob Lester, MPP	Nancy McIntosh
Alvaro Ballesteros, MBA	Brad Land	Monique Tula	Melissa Roldan
Joseph Cadden, MD	Patsy Lawson/Miguel Palacios	Terrell Winder	Juhua Wu
Raquel Cataldo	Ted Liso/Douglas Lantis, MBA	Fariba Younai, DDS	
Michelle Enfield	Abad Lopez	Richard Zaldivar	
Dahlia Ferlito, MPH *(pending)*	Marc McMillin		**COMMISSION STAFF/CONSULTANTS**
Suzette Flynn	Ismael Morales		
Aaron Fox, MPM	Jose Munoz	**COMMISSION MEMBERS ABSENT**	Dawn McClendon
Lynnea Garbutt	Angélica Palmeros, MSW		Jane Nachazel
David Giugni, LCSW	Mario Pérez, MPH	Lilia Espinoza, PhD	James Stewart
Terry Goddard, MA	Gregory Rios/Jenny O'Malley, RN, BSN	Victoria Ortega	Craig Vincent-Jones
Joseph Green/Erik Sanjurjo, MPH	Juan Rivera/Rev. Alejandro Escoto, MA	LaShonda Spencer, MD	Nicole Werner
Kimler Gutierrez *(pending)*	Maria Roman		
David Kelly, MBA, JD	Jill Rotenberg		
Ayanna Kiburi, MPH (by phone)	Sabel Samone-Loreca/Susan Forrest		
PUBLIC			
Robert Aguayo	Ernesto Aldana	Herman Avilez	Vicki Ashley-Johnson
Margarita Barragan	René Bennett	Maria Calleros	Edd Cockrell
Alicia Eccles	Miguel Fernandez	Taryn Feuerberg	William Flores
Francis Greene	Tanya Hendricks	Carl Highshaw	Faith Idemundia
Faith Landsman	Joseph Leahy	Aldo Macias	Andres Magana
Elizabeth Mendia	Andre Mollete	Kenneth Ramos	Laura Ramos
Martha Ron	Gayle Rutherford	Adrianne Sam	Matt Spencer
Rudy Tenorio	Thomas Tran	Tzeli Triautafillozi	Brigitte Tweddell
Jason Wise			

1. **CALL TO ORDER**: Mr. Rosales opened the meeting at 9:20 am.

A. Roll Call (**Present)**: Cataldo, Enfield, Ferlito, Flynn, Forrest, Fox, Garbutt, Goddard, Green, Gutierrez, Johnson/Donnelly, Kelly, Kiburi, King, Kushner, Lawson, Liso, Lopez, McMillin, Munoz, O'Malley, Pérez, Rivera, Roman, Rosales, Rotenberg, Smith, Tran/Lester, Tula, Zaldivar

2. **APPROVAL OF AGENDA**:
MOTION 1: Approve the Agenda Order with Motion 7 withdrawn ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
A. April 11, 2013:
B. October 10, 2013:
C. November 14, 2013:
D. December 12. 2013:
MOTION 2: Approve, and revise as necessary, the minutes from the April 11, 2013 Joint Commission on HIV/Prevention Planning Committee (PPC) meeting, the October 10, 2013 and December 12, 2013 Commission on HIV meetings, and the November 14, 2013 Commission on HIV Annual Meeting, as presented ***(Passed by Consensus)***.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
- Mr. Molette, AIDS Project Los Angeles (APLA), announced the second Twitter town hall, Black Out LA, "ACA and You," 2/26/2014, 6:00 pm to 8:00 pm, APLA Health and Wellness, 3743 South La Brea. It is devoted to fighting the HIV epidemic in South Los Angeles and Black communities with young, Black, gay men talking about ACA and how it affects them. Follow the town hall on Twitter, #BLACKOUTLA; Facebook, blackoutla1; or streamed live at www.youstream.com/blackoutla.
- Ms. Feuerberg, Asian Pacific AIDS Intervention Team, announced a 3/6/2014 open house for women's programs featuring the new, free SAMHSA-funded Project HEAL for women of color who have experienced substance abuse and trauma/PTSD.
- Ms. Landsman, Director, Research Study Volunteer Project, UCLA, said over 400 people are registered and receiving offers to join studies. Registration remains open for those 18 or over, HIV+ or HIV-, high- or low-risk, men or women including transgender men or women. Incentives are available. UCLA is also hiring for a clinical research and a financial position.
- Ms. Eccles, Eban II Project, UCLA, reported the first two groups at APLA and AIDS Healthcare Foundation continue to recruit African-American, serodiscordant, heterosexual couples for the eight-week program to enhance communication skills and relationships and learn about protecting each other. A part-time recruitment specialist position is also open.
- Ms. Idemundia, Center for Behavioral and Addiction Medicine, UCLA, works with Dr. Steven Shoptaw. Their new cohort study, MASCULINE, focuses on young, African-American and Latino, MSM, high-risk HIV+ and HIV- and how their non-injection drug use affects HIV transmission and progression. UCLA is working in conjunction with the LA Gay and Lesbian Center (LAGLC) on the study. Recruiting will begin in the next few months.
- Mr. Ramos, APLA, grew up on the reservation and is the new prevention training specialist for the Red Circle Project, Health and Wellness. The Red Circle Project has released a new series of role model stories which integrates the CDC's community-level intervention, Community Promise. It is also preparing for National Native HIV/AIDS Awareness Day on 3/20/2014 with events in Los Angeles on 3/19/2014 and in Palmdale on 3/21/2014. Native client referrals are always welcome.
- Ms. Tweddell, Project New Hope, reported HUD has changed requirements for Shelter+Care for PLWH. Changes are expected for other Section 8 programs. Providers must shift their focus from housing homeless PLWH to housing chronically homeless PLWH. That is an issue because providers cannot find chronically homeless PLWH in notable numbers. PLWH in transitional housing are not considered chronically homeless so PLWH who are homeless or in transitional housing cannot be assisted until they are chronically homeless. Project New Hope's wait list for Shelter+Care has gone from 120 PLWH to 0.
- The Los Angeles Homeless Services Authority, a joint powers authority of the City and County, is the grantee for HUD funds. Ms. Flynn added the Housing Authority of the City of Los Angeles receives funding for vouchers and has been advised. A key issue is the HUD definition of "chronically homeless." Disability is counted as one point and is not weighted for HIV. Another meeting is planned to review possible discrimination or disparate impact on PLWH, but regulatory issues are involved.
- "Chronically homeless" means at least four documented instances of homelessness in the past two or three years.
- Mr. Goddard added all the HUD-funded supportive housing and many continuum programs are affected. A single-entry system is also being designed that uses a vulnerability index to prioritize clients. The index does not prioritize PLWH.

➲ Ms. Flynn will update the Commission if there are new developments in talks with the City regarding housing and will forward relevant housing documents to staff for Public Policy Committee review.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**:

- Ms. Forrest said Coping with Hope 2014, "The HIV Care Continuum," will be 5/22/2014, California Endowment. The free, one-day symposium on PLWH mental health needs is primarily for mental health providers and nurses. CEUs are available.
- Mr. Zaldivar requested a written report on the number, facts and dispositions of lawsuits filed against the County as well as a report on the history of lawsuits against the Commission. He felt the Commission needs to be better informed.
- Mr. Fox announced Luke Klipp, former State Affairs Specialist, APLA, is now with LA Metro. Transportation has long been his passion. Mr. Fox suggested a thank you letter for his service to the Commission as a committed community voice.
- Mr. Smith noted the CDC has shifted its HIV prevention priorities from focusing on high-risk HIV-s to PLWH who are in or have fallen out of care. That places the onus of prevention on PLWH. He urged discussion on how to continue addressing needs of HIV- people including continued medication for those in current PEP and PrEP research studies. The ACA will not address all disparities. Social determinants of care that create barriers and responses to them must be addressed.
- Mr. Pérez, Director, DHSP, said he would address the CDC change and PEP/PrEP in his presentation. He agreed that, while the ACA is remarkable, there may be unintended consequences for populations we have historically served. Disparities may be exacerbated if health plans and systems are not as robust and do not fully address the population's holistic needs.
- Mr. Johnson referenced his December 2013 American Bar Association Journal article in the packet as a primer on the need for managed care plans to work with community clinics for populations at risk such as the homeless.

6. **CONSENT CALENDER**:

A. Policy/Procedure #08.2107: Consent Calendar:
MOTION 3: Approve the Consent Calendar with Motions 5, 6 and 9 pulled for discussion ***(Passed by Consensus)***.

7. **PARLIAMENTARY TRAINING**: There was no training.

8. **CO-CHAIRS' REPORT**:

A. California Planning Group (CPG) Representative:
MOTION 4: Ratify the December 12, 2013 election of Commissioner Juan Rivera as the Commission's representative to the California Planning Group (CPG) for the State Office of AIDS (OA) ***(Passed as Part of the Consent Calendar)***.

B. Commission/Committee 2014 Work Plan(s): Committees were encouraged to complete their plans as soon as possible.

C. Current Co-Chair Terms:
- Mr. Rosales noted terms were not included in the co-chair election motion. One term ends this December and the other in December 2015 to initiate staggered terms. Nominations open in July with a Co-Chair Elect chosen in August.
- Co-Chair terms were decided at the last Executive Committee meeting. Mr. Rosales will serve the term ending this year.

D. Member Departures: Harold Sterker and Dr. Mark Davis have both resigned due to increased work responsibilities.

9. EXECUTIVE DIRECTOR'S REPORT: Mr. Vincent-Jones noted four committees now meet in the fourth week of the month and the fifth in the first week. All generate work for the Commission so bunching them, particularly with the staff shortage, makes it hard to prepare materials in time. Executive and Operations set the Commission agenda so need to maintain their schedules, but the others can be moved up one week to spread work out.

A. Creating a Commission Impression: Branding:
- Mr. Vincent-Jones noted the Commission generates a wealth of information, but has not disseminated it well. He hopes to improve dissemination of that material, e.g., videotaping and transcribing colloquia to increase access.
- Publications are also being developed. They must be reviewed for accuracy, but also designed to present a professional and easy-to-navigate look. Presentation should speak to the issues and the underlying morality of the Commission.
- It became apparent in discussions with the content designer that improving dissemination includes re-imaging or rebranding the Commission. Branding provides a positive image of an organization that people come to recognize as the hallmark of an informative, reliable and helpful organization. Creating a new image or brand is a major effort that ordinarily would be deferred at this point, but delay would undercut efforts to improve dissemination.
- Branding is generally built around an organization's logo so developing a new one became the natural first step. Logos can be developed through marketing surveys and focus groups, but that can take up to a year at significant cost.
- The Commission is a new, integrated body so that, in itself, lends itself to a logo that reflects a new image. The current Commission is a black County seal over a red ribbon. Many planning councils likely have similar logos.

- The content designer was asked to develop something fresh. Ms. Tula suggested a reference to STDs. Mr. Vincent-Jones replied most logos have little, if any, content. Large corporations such as Apple often use a stand-alone symbol. Such bodies, however, have large budgets to familiarize the public with their logo and their concept is simple.
- Smaller organizations often include their name or a tagline. The Commission is unlikely to find a stand-alone symbol that represents its complete mission. Logo options provided include some that use just the name and others that include a symbol. There are few symbols that express HIV. He did not know of any STD symbol. It might have been included in the name during Ordinance changes, but it would not be feasible to make such a change now.
- He and the designer tried to represent issues with different graphics and color schemes. A logo's color scheme or motif informs how it is used in different circumstances, e.g., a more sedate color scheme will result in less exuberant designs.
- Logos are varied to serve the use and audience. A logo sheet provides a primary logo and its variations, e.g., for use in color versus black-and-white publication or for vertical versus horizontal use. Each sheet identifies primary logos for color and for black and white with variations of the two. Option 2 also offers two color schemes: 2a and 2b.
- Option 1 experiments with color. There is no symbol so "Los Angeles County COMMISSION ON HIV" is the symbol itself.
- Option 2a stresses color. Originally colors were more rainbow-like, but several felt associations with other uses were distracting so the palette was adjusted. The main drawback is a white rather than red ribbon which may not translate.
- Option 2b addresses color photocopying issues with a more limited palette and uses a more identifiable ribbon.
- Option 3 is a different symbol version. Its main drawback is a fairly dark presentation which may not be the desirable image, may be difficult to reproduce clearly and may seem Imbalanced if the rest of a publication is light.
- Ms. Roman felt several color logos suggest LGBT pride, e.g., Option 1. Mr. Sanjurjo liked Option 1 with other colors.
- Mr. Lester asked if the red in Option 2b reproduced accurately. Mr. Vincent-Jones said it was intended to be an offset of red. The red can be changed if commissioners like the design, but prefer a truer red.
- Mr. Kelly said most documents are eventually Xeroxed so attention should be paid to black-and-white versions. He was unsure whether the ribbon was a positive or negative in lieu of stigma in the community. He also was concerned about inclusion of STDs and suggested renewing the discussion on including it in the name.
- Mr. Vincent-Jones replied a high resolution professional design produces a crisper product for copying though darker versions present more challenges. He did not want to initiate an Ordinance name change now as it would take at least six months especially with two supervisors terming out. Products for dissemination are now in development so a wholesale logo change later would lack continuity. He hoped a logo chosen now could be adapted to include STDs later.
- Mr. Zaldivar said the logo is not really for commissioners, but for public branding. STDs are key and should be included. Rebranding should only be done once a generation. It takes time and is costly, e.g., to print new stationary and business cards. He recommended waiting until STDs were reflected and then doing a branding launch.
- Mr. Land asked why the current logo with the AIDS ribbon was not an option. Mr. Zaldivar felt the AIDS ribbon referred to AIDS – not HIV and STDs – so believed it looked to the past rather than to the future.

MOTION 5: Select a new Commission on HIV logo and variations from among those presented ***(Withdrawn)***.
MOTION 5A: ***(Zaldivar/Land)*****:** Refer logo selection process to the Operations Committee for further action ***(Passed by Consensus)***.

10. **DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT**:
    - Mr. Pérez acknowledged DHSP presentations are not always submitted timely for the packet, but that will improve.
    - He recently engaged the senior management team in a series of exercises to outline 2013 accomplishments as well as high priorities DHSP did not complete. Many 2013 priorities were accomplished. Others were not. Most priorities pertained to program and service delivery, but some focused on internal administrative efficiency and operations.
    - DHSP continues to face multiple time demands. As part of the exercise, the team will identify 2014 HIV and STD system priorities. Review will be complete in approximately one month and will rethink some service categories with the Commission, look at internal capacity to release RFPs and review essential program refinements, e.g., in the jails.
    - HRSA has still not informed DHSP about the balance of the Ryan White Part A grant award. It is unlikely there will be notification until the Federal budget is approved. HRSA has committed approximately 25% of last year's award to date.
    - HRSA is expressing an unprecedented increased appetite for DHSP to consider Part C investments to County clinics in investing Part A resources. Part C funds approximately $7 million for a dozen providers to support HIV clinical-related services. Scrutiny has increased and the issue has been raised in budget exercises. He expects this will be an ongoing Federal expectation. Consequently, he requests incorporating Part C and other Ryan White funds in PP&A deliberations.
    - Mr. Ballesteros said PP&A discusses other funding including Part C, but needs regular data. Mr. Pérez said DHSP continues to request Part C data from its partners. Not all have complied. Part D investments will also likely be included at some point.

A. Research/Surveillance: Mr. Pérez said the CDC continues to revise its countrywide estimate of the number of undiagnosed PLWH. It was 21% for many years, was then reduced to 20% and is now 18.1%. Dr. Douglas Frye has reviewed and agreed with the new CDC approach. Consequently, the County estimate for undiagnosed PLWH was originally 13,000, was reduced to 12,800 and is now slightly over 10,000. The overall HIV burden has also been reduced to approximately 58,000.

B. STD Services: There was no additional discussion.

C. HIV Services:

1. ***Overview of DHSP's HIV Prevention Response***:

- Mr. Pérez reported approximately 2,000 new infections in the County annually, a fairly stable number. It is hard to measure prevention effectiveness, but DHSP's response spans the County with a focus on high-impact zip codes.
- The County consists of approximately 4,000 square miles with two large mountain ranges. Services are not offered in the mountains, but they divide communities including some with high rates of HIV-related co-factors, e.g., the Antelope Valley has approximately 600 PLWH, but also high rates of teen pregnancy and STDs. Hollywood/West Hollywood is the epicenter with over 40% of PLWH and approximately 800 annual infections in SPA 4.
- The current estimate of PLWH in the County is 58,000 with the estimate of those undiagnosed reduced to 10,000. The National HIV/AIDS Strategy (NHAS) goal for undiagnosed PLWH is 10% or, for the County, 5,800.
- Of diagnosed PLWH, 77% are linked to care, 56% retained in care, 50% on ART and 42% have a suppressed Viral Load (VL). DHSP requested RAND Corporation model the most effective use of prevention funds a few years ago. It recommended a focus on suppressing VL in diagnosed PLWH. Those who fall out of care or intermittently take medications have high VLs that push infection. Stabilizing VLs can reduce infections from 2,000 to 1,000 to 500.
- The CDC funds prevention. It has become more prescriptive. In 2010, it began to address coordination and service integration among HIV, STD, Hepatitis and TB programs yet the structure remains siloed. The County addressed co-infections by integrating HIV and STDs, but adult viral Hepatitis and TB remain functionally separate. The San Francisco jurisdiction has gone the furthest by deconstructing and revising their entire health department.
- Testing and Linkage to Care Plus (TLC+) became the buzz word in 2009-2010 based on several landmark studies that launched a sea change to test, diagnose and link people to care and treatment to get ahead of the epidemic.
- NHAS was released in July 2010 and the CDC funded a separate Enhanced Comprehensive HIV Prevention Planning (ECHPP) grant in September 2010 for 12 jurisdictions to think critically about their overall HIV prevention portfolio.
- The County funded the RAND model with ECHPP and formed a work group in 2011 to coordinate TLC+ proposals.
- In June 2011, the CDC released a new FOA which changed its funding formula for the first time since 1993. The formula shifted funds from low- and medium-impact jurisdictions and toward those where the epidemic was on fire, e.g., the SouthEast, and those with a longstanding, underfunded epidemic, e.g., Florida. County funding was stable. The CDC also became more prescriptive based on its High-Impact Prevention model.
- The DHSP integration was announced in February 2011. DHSP launched its new HIV testing model, New Directions, in July/August 2011 which reimbursed providers for performance.
- The RAND analysis was completed in May 2012 and the CDC released its new HIV planning guidance that July.
- Medical Care Coordination (MCC) was launched in January 2013. There are now 41 patient-centered medical homes in the County's Ryan White clinics. MCC has a prevention component because it tethers the most acute PLWH to an RN and social worker who address psychosocial issues which foster adherence and VL suppression.
- There are multiple elements to prevention such as addressing behavioral change with mental health services or addiction, diagnosing and treating STDs, and biomedical interventions. The CDC also requires condom distribution.
- The question is whether funding prevention directly or changing the rules of engagement will be most effective for the greatest cross-section of the population. For example, what would be the impact if Kaiser were required to screen all gay men for HIV infection every six months or if every Federally Qualified Health Centers (FQHCs) were required to have a holistic approach to serving the transgender population?
- Many believe policy interventions can have the greater impact, e.g., a California law that required routine opt out HIV testing for all those in a health system would probably reduce the number of the undiagnosed.
- The CDC has a four-page summary of its prevention approach which is linked on the DHSP website. It prioritizes: Category A, High Impact Prevention (HIP) including specific HIP programs; Category B, expanded testing with 70% of funds for routine testing and 30% for targeted testing; and Category C, demonstration projects. The County has historically focused on targeted testing, but has developed partnerships to foster routine testing capacity building.
- Category A mandates 75% of funds for core prevention programs: testing, comprehensive prevention with PLWH, condoms and policy initiatives. 25% is available for other proven activities: Effective Behavioral Interventions (EBIs)

for high-risk populations, social marketing, PrEP/nPEP. County programs include locally developed interventions, e.g., contingency management with a PEP option for stimulant users in a very high burden Hollywood area.

- The CDC Guidance also supports a planning body informing how prevention funds are allocated; capacity building and Technical Assistance; and program planning, monitoring and evaluation, and quality assurance.
- The total grant is $15.6 million showing just a slight decline from the high of $20 million some eight years ago.
- Category A DHSP Programs are: targeted HIV and STD testing; comprehensive risk and counseling services for high risk populations; faith-based programming to change attitudes and norms around HIV; LTC; condom distribution; a policy initiative on use of laboratory surveillance for public health purposes, e.g., where new diagnoses are located, what proportion of PLWH have suppressed VLs and partner follow-up; HE/RR; and social marketing.
- Category B expanded testing is funded at multiple sites including the jails and 12 STD clinics which do a combined 18,000 annual tests. DHSP also works with Gilead's testing initiative to ensure complementary efforts.
- Category C demonstration projects are HIV surveillance for public health purposes, e.g., syndemic planning; Project Engage; and the Navigation Program.
- Testing is provided at 12 Public Health STD clinics, but many youth avoid them so the Department of Public Health (DPH) is changing the conversation about how youth consume services to make the clinics a preferred option. Testing is conducted at a community-based STD clinic; 5 community wellness centers; 4 community clinics; and two County Jails, the Men's Central K6G Unit and Central Regional Detention Facility for women. Mr. Pérez felt there are significant opportunities to do more at the 11 commercial sex venue testing sites.
- Nine Mobile Testing Units include four that test for both HIV and STDs. DHSP continues to review the model. It takes a long time to set up each van for a day of testing, but they offer significant access in underserved areas. Testing is also offered at 12 storefront testing sites, an emergency department and 2 court sites.
- DHSP achieved a record number of just under 140,000 HIV tests in 2013. Its goal was to test the number needed, based on 1% positivity, to reach the NHAS goal. Diagnoses have increased and repeat tests decreased for those already diagnosed who received their results and counseling. There have been up to 40% repeat tests at some sites. DHSP urges providers to ask about prior testing to reduce unnecessary repeat testing costs.
- The CDC supports HE/RR EBIs and the Diffusion of Effective Behavioral Interventions (DEBIs) nationwide. DHSP funds nine EBIs often targeted to a specific risk group. The CDC reviews EBIs with promising outcomes as possible DEBIs. Of County interventions, 45% are EBIs or DEBIs and 45% are locally developed interventions.
- DHSP uses syndemic planning to look at HIV and STD surveillance data together for a more accurate overall STD picture. It focuses on connections between HIV, syphilis and gonorrhea co-factors in health program review. Raw data mapping ignores supervisorial districts, cities and SPAs to identify where people with STDs live, e.g., one 48 square-mile cluster represents approximately 46% of PLWH in the County.
- In future directions, Mr. Pérez said DHSP is working to re-solicit and modernize its prevention portfolio to more strongly consider reach and effectiveness, e.g., EBIs may have a significant impact but, if so, they impact only a couple of thousand people who may not be at the highest risk of transmission. While there is a role for small interventions, most effective interventions should also be scalable to increase numbers impacted.
- DHSP continues to improve: HIV care and prevention services based on data and evidence-based outcomes; and HV and STD testing/screening and diagnosis, and treatment efforts. DHSP will also implement its LTC program.
- There are 64,000 diagnosed STDs countywide with increased syphilis since the late 1990s and gonorrhea especially among African-Americans. Migration of a resistant gonorrhea strain to California is a concern for the future.
- STD testing and treatment need to be integrated into HIV prevention where it makes sense, e.g., Mobile Testing Units (MTUs) provide rapid HIV testing results in 20 minutes. A chlamydia and general gonorrhea test can be done from a urine sample tested at the Public Health Laboratory with results possibly provided electronically. Self-collected rectal swabs can also be used to test for gonorrhea, but that adds complexity to the MTU. A non-blood-based rapid syphilis test is in development, but only blood draws can be used now.
- An MTU could also include an RN to treat those who present with symptoms, but an RN costs approximately $100,000 annually and might not see anyone who needs STD treatment on an MTU for days at a time.
- DHSP is working to finalize and launch the Second Supervisorial District Enhanced STD Control Strategy in response to the highest STD rates and biggest disparities of any area. The Strategy involves a broad cross-section of partners.
- 2014 is the first of a five-year STD Prevention Cooperative Agreement. For the first time, the CDC is not prescribing activities, but rather is asking jurisdictions to evaluate the best possible planning. DHSP welcomes input.
- Ms. Samone-Loreca asked if DHSP knew why African-Americans are especially impacted by gonorrhea, age ranges and how many are newly diagnosed as HIV+. Mr. Pérez said the highest chlamydia burden is among women <25.

Transmission is usually to or from their male partners so making sexual health a valuable commodity for young men is a goal. Gonorrhea persists among both men and women, but is uneven among racial/ethnic groups.

- The gonorrhea risk profile is similar to that of HIV. Black men actually have less risk for both than their white and Latino counterparts, but the epidemics are so entrenched that exposure rates are higher, e.g., a Black woman has an eight-fold greater risk of infection than a woman in a different zip code. It must be addressed community wide.
- There were approximately 10,000 cases of gonorrhea diagnosed in the last complete year countywide. Rates per 100,000 are significantly higher for Black men and women. They are available on the website. How many people were also newly diagnosed with HIV can be assessed from data reports.
- Mr. Land asked about social marketing. Mr. Pérez noted the County has 10 million people with 99.4% HIV- and 0.6% HIV+. The key question in a vast geographic area is the cost effectiveness of broad marketing to mostly HIV- and low-risk people. That is why DHSP has done significant targeted marketing.
- Mr. Smith requested a presentation on surveillance and the role of public health investigators. He would also like to see the treatment cascade by population as well as any MCC utilization data. Mr. Pérez replied DHSP has treatment cascade data by race/ethnicity though not all sets are equally strong due to population size.
- Preliminary MCC impact data in aggregate suggests the 41 MCC medical homes are seeing better viral suppression because of the RN/social worker teams designed to address the needs of the most acute patients.
- Ms. Tula asked about DHSP and Gilead testing investments. Ms. Bennett, Regional Lead, Los Angeles FOCUS Initiative, Gilead, said FOCUS started in 2010 and works in 11 cities with government agencies, hospitals, FQHCs and community organizations to foster routine HIV testing. It is beginning to work on Hepatitis C testing.
- In Los Angeles, FOCUS partners with seven FQHCs, LAC+USC Emergency Department and a few other substance abuse treatment centers and community-based organizations. There are eight partnerships with two partnerships in process and more planned. She cannot share budget information prior to checking with Gilead.
- Regarding DHSP, Mr. Pérez reported the current investments are $8.4 million for testing and $7.8 million for HE/RR. Those proportions have switched over time. Historically the County spent approximately 25% on testing.
- He added DHSP continues to meet with hospital and other system leaders. Even they remain reticent to be the first to offer routine testing because of the continuing stigma of old cultural and philosophical reasons.
- Mr. King noted for years many community-based organizations focused on services for HIV- people. He asked what organizational and program level suggestions Mr. Pérez had for such organizations to transition to the new focus.
- Mr. Pérez was reluctant to reply directly, but noted personal views on where the siloed approach is heading. The ACA is writing on the wall. The County has over 170 FQHCs and Community Health Clinics. The CDC is much more prescriptive about categorical HIV prevention funding and the State no longer invests any General Fund monies. People are eager for health plans and Medicaid/Medicare systems to absorb patients. Some providers have forecast well. Others not. The door is closing and DHSP should not be considered the sole HIV prevention funder.

➲ Mr. Pérez will scan and forward to Mr. Vincent-Jones the CDC four-page prevention program summary.

➲ Mr. Pérez will provide treatment cascade data by race/ethnicity and provide an estimate on when preliminary MCC effectiveness data including demographic information will be available for release.

12. PUBLIC HEALTH/HEALTH CARE AGENCY REPORT(S):

A. Discussion with Medicaid Expansion Health Plans: LA Care:

- Ms. Calleros, Director, Safety Net Initiatives, introduced Thomas Tran who is the point person tracking planning for key priorities and issues pertaining to PLWH. Mr. Fox noted Health Net was invited, but could not come.
- Ms. Calleros provided an update on the transition of patients from the Low Income Health Program, Healthy Way LA (HWLA) in the County, to Medi-Cal starting 1/1/2014. Of 305,000 total HWLA patients, 293,000 transitioned into Medi-Cal automatically 1/1/2014, 4,000 were ineligible and 8,000 to 10,000 did not transition due to system communication problems between the State and County. The County is working with the State to correct the problem and the State will provide Medi-Cal to affected patients retroactive to 1/1/2014. Some have already transitioned to Medi-Cal.
- LA Care and Health Net are the two Medi-Cal managed care plans in the County. LA Care has partnerships with over 30 Independent Practitioner Associations (IPAs) and three plans. Health Net has a similar structure. Transitioning patients were assigned to one of the two Medi-Cal managed care plans.
- LA Care received 165,000 members on 1/1/2014 with 88% assigned to their prior medical home identified by the State via electronic matching with County HWLA plan information for those who did not choose a health plan or provider.
- Approximately 12% of patients transitioned to LA Care were not assigned until 12/27/2013 and 12/30/2013. Clinic medical home information was not provided for them. LA Care auto-assigned them to a community or County clinic

since the HWLA provider network was comprised of such clinics. LA Care also worked with HWLA to identify their network clinics and facilitate contracts for them with LA Care or Health Net. Just one remains to be linked to a plan.

- LA Care had a much higher call volume than anticipated despite hiring and training new staff. Not receiving either an LA Care or State Medi-Cal identification card to facilitate access to care was the most reported problem.
- The next highest call volume was related to medical home changes especially for those auto-assigned. LA Care has instituted a fax notification process for such changes as an alternative to calling. Clinic partners have been advised and can fax a notification on the same day they see a patient. Notifications are processed within 48 hours.
- LA Care expected continuity of care issues and set up a unit to resolve them. It is assisting patients, but volume is lower than expected possibly due to preparation, e.g., including HWLA clinics in the network. LA Care worked with the County Department of Health Services (DHS) to continue specialty care as DHS did for HWLA. LA Care pays for the services. It is also urging clinics to provide services despite assignment issues. LA Care will address payment on the back end.
- Pharmacy was another area of concern. LA Care ensured its formulary was comprehensive and confirmed with the State Department of Health Services that it would seamlessly continue to cover antiretrovirals. The only problems have been for those 8,000 to 10,000 patients caught in the system transition issue who have temporarily lost all coverage. The County has put a solution in place to assure medications for those patients until the issue is resolved.
- LA Care feels it is still at the beginning of planning efforts and strategies to provide optimal PLWH service. It continues to meet with the Department of Public Health (DPH). One area of focus is membership engagement especially to educate members about their health care coverage, benefits and how to access services or assistance. It is developing an outreach campaign to former HWLA members to introduce them to principles of healthcare coverage.
- LA Care has gathered input from DPH and the Commission including the Consumer Caucus. It has also researched approaches. There will be a series of communication and engagement strategies that develop over time. Feedback emphasized simple messages and use of technology. The first step will be a small communication such as a postcard affirming coverage and that there are people available to help. Details are being developed, e.g., while LA Care has a customer service line, it might be preferable to have one number for both LA Care and Health Net.
- Mr. Fox asked if there will be targeted social marketing to communities with disparities. Ms. Calleros said that is planned, but LA Care wants more input including meeting with the Transgender Caucus.
- Ms. Calleros noted a need to also develop provider education strategies. Many traditional HIV providers are connected to the system. Others have not previously offered services to PLWH so are unfamiliar, e.g., with the continued availability of Ryan White wrap-around services especially regarding psychosocial services.
- Ms. Enfield asked about transgender population provider education. Ms. Calleros said LA Care has a contracted network of providers so is responsible to train, educate and raise awareness about patient needs. It wants to develop a broader education strategy including partnering with DPH and specific education for providers not familiar with PLWH.
- Mr. Tran said Health Net providers will also need education so it could be a joint effort with DPH and the Commission. Ms. Calleros added, while Health Net is technically a competitor, it may make sense to collaborate. Mr. Fox commented there are now trusted Ryan White providers in the system that can help with education about specific communities.
- Medi-Cal expansion increased mental health and substance use benefits, a major improvement. LA Care contracted with Beacon which has a network of mental health providers. DPH will continue to provide substance use benefits. LA Care will continue to work on coordinating benefits and ensuring patients are aware of them.
- Prevention is also a key priority. DPH has that role and responsibility to ensure community health, but LA Care also has a role since it now delivers care to many more people, e.g., in leveraging DPH work via more integration into the plan.
- Ms. Samone-Loreca asked how LA Care addresses HIV- transgender women seeking specialty care. Ms. Calleros said services such as hormones are covered. Services such as mammograms follow normal procedure. Providers have a schedule to offer adult prevention services and guidelines with an initial assessment and education that screens for issues. There may be a need for provider education on transgender community medical needs and services.
- Regarding the homeless and undocumented, Ms. Calleros noted undocumented individuals are not eligible for any ACA health insurance so they will continue to be covered by other systems such as Ryan White.
- LA Care and Health Net estimate that jointly they will provide coverage for approximately 50,000 patients who are most likely homeless. LA Care is working to learn how to engage with that population. They can access testing through the regular clinic sites that they might access today, e.g., there are homeless service agencies such as JWCH that work to provide and coordinate services to help them access medical care when needed.
- Mr. Johnson felt the community planning body really needs data sharing from our partners especially as data matures and can reflect services provided and issues encountered. The more data received the more effective the planning

body can be in planning Ryan White wrap-around services. Ms. Calleros noted LA Care was just beginning its data collection though some clinical data was obtained from the County for transitioning patients.

- She felt it would be helpful in continuing planning efforts with DPH to discuss how data will be used, what trends are of interest for monitoring and what will be informative for future decisions. Commission input would be helpful.
- Mr. Land asked if there has been progress in contracting with Kaiser for better coordination with County providers. Mr. Fox replied Kaiser is a different health plan and a closed health system. Ms. Calleros noted LA Care has a very small contract with Kaiser, but they limit their enrollment primarily to those who previously had a Kaiser plan. LA Care will try to help educate Kaiser about the value of coordination and is willing to take specific concerns to them.
- Mr. Fox asked about PEP, PrEP and routine testing. Ms. Calleros said routine testing is covered within the health plan. The patient's primary care physician can direct the patient where to access services. PEP and PrEP medications are accessed through the State Fee-For-Service system on the Medi-Cal side.
- Mr. Fox added LAGLC has helped patients access PEP quickly through Medi-Cal. The Department of Health Care Services currently requires a Treatment Authorization Request for PrEP though there are efforts under way to make that easier. He noted there may be pushback due to cost as demand increases.
- Mr. Ballesteros noted differing views on asking new members whether they are LGBT at their initial screening. He felt it critical to collect data to evaluate whether the LGBT community is being served well, e.g., whether high-risk people are routinely offered testing, there is prevention counseling or transgender women are offered appropriate tests. That is not a subject that will be solved soon, but he felt it is a conversation the Commission should have.
- Ms. Calleros said the State requires health plans to track certain data based on quality metrics for the plans. Data is not collected that identifies specific communities, but LA Care is willing to participate in those State policy discussions.
- Mr. Fox said Covered California has tentatively agreed to collect voluntary gender identity and sexual orientation data on their application. He urged each health plan to allow people to identify voluntarily when collecting demographic data. Ms. Calleros said that data is now collected through the Medi-Cal enrollment process, not the health plan. Data might be collected at the required initial health assessment if people preferred health plan level collection. Mr. Fox said Medi-Cal enrollment data is at the State level while plans could use data to evaluate engagement in various services.
- Mr. McMillin, a Long Beach consumer, reported an issue with a Long Beach Department of Health and Human Services (DHHS) contract. He was concerned the issue will disrupt retention in care for patients who wish to access care via DHHS. Ms. Calleros said LA Care is already working on resolving the issue by linking an IPA to the network.

13. HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) REPORT:

- Ms. Flynn, Director, Program Operations, Housing and Community Investment Department, City of Los Angeles, said Program Operations includes HOPWA. She thanked Mr. Vincent-Jones for inviting her to apply for the Commission because she firmly believes the City and County must work together to provide the best PLWH services. She also is working collaboratively with the County on homeless programs including development of an innovative program for families.
- Housing Opportunities for Persons With HIV and AIDS (HOPWA) was established through the National Affordable Housing Care Act of 1990, authorized by the AIDS Housing Opportunity Act of 1992 and is administered by the Federal Housing and Urban Development (HUD) Office of HIV/AIDS Housing. The program provides housing assistance and related supportive services for low income persons with HIV/AIDS and their families.
- HOPWA is an entitlement funded annually through the City's Consolidated Plan and administered through the Housing and Community Investment Department. The Department previously was the Los Angeles Housing Department. Last July that merged with the Community Investment portion of Community Development which no longer exists.
- The Department has approximately 700 employees. It operates multiple programs including: affordable rental housing development, minor home repair, lead-based paint hazard, first time home buyer, rent stabilization in the City, systematic code enforcement, neighborhood stabilization, City family resource centers and domestic violence centers.
- The HOPWA Unit has four full-time positions with one vacancy. Federal entitlement funding for this year is $13.3 million in addition to a $2.7 million rollover for a total of approximately $16 million. Funding was used to contract with 22 nonprofit agencies and four public housing authorities. While funding comes to the City, HOPWA operates countywide. Funding also supports a technical service advisor and a fiscal monitor.
- Nonprofit agencies are contracted through an RFP process. The last bid process was in 2011 with contracts starting 10/1/2011. The next RFP will probably be released later this year for contracts starting 4/1/2015.
- HOPWA regulations allow a wide variety of services, but the City mainly funds housing subsidy assistance and supportive services. Short Term Rent, Mortgage and Utility Assistance provides clients financial help to maintain permanent housing. They must have a financial issue due to their HIV condition or loss of income. Those in subsidized housing are not eligible.

- The Permanent Housing Placement Grant provides security deposits, first month's rent, utility turn on and other related moving costs. There is also a scattered site master leasing program offered by two agencies that master lease rental units from property owners, usually of market rate developments, with units subleased to eligible HOPWA clients.
- TANF-Based Rental Assistance is a large program operated through the four public housing authorities: City of Los Angeles, County of Los Angeles, Long Beach Housing Authority and Pasadena CDC. The program provides up to 12 months of rental assistance for low income PLWH and their families. It converts to the regular Section 8 program after 12 months so that people receive permanent housing. It used to have approximately 300 clients. Due to sequestration, only the Long Beach and Pasadena housing authorities are continuing to convert clients to Section 8. The program may restart this year.
- HOPWA also funds rental assistance directly to units at two affordable housing developments in West Hollywood and operating costs for 39 emergency shelter beds and 167 transitional housing beds.
- Supportive services are important to help people stay in housing. It mainly pays for housing specialists to help people locate, move into and stay in housing. It also pays for other services including: residential service coordinators in affordable housing developments, food and nutrition, benefits counseling, mental health counseling, legal services and training.
- HOPWA funds a contractor to run a housing information clearing house website, www.chirpla.org. It was accessed by 36,000 people last year and can be searched by area, zip code, type of housing desired and supportive services.
- Occasionally HOPWA will have additional funds available to use for permanent supportive housing development. Funds are used to leverage other types of Federal funding sources, e.g., last year SRO Housing received $2 million to build a 108-unit property. Fifteen of the units are set aside specifically for PLWH.
- The Los Angeles Countywide HOPWA Advisory Committee (LACHAC) advises the Department on implementing HOPWA program goals. Three commissioners are on LACHAC and nine are funded by HOPWA so there is already some integration.

14. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. OA Work/Information:

- Ms. Kiburi announced Aileen Barandas is OA's new Quality Management Coordinator for the Ryan White Part B HIV Care Program. Her primary role is implementing OA's quality management program including requirements for Part B funded Local Health Jurisdictions. She will also be available to help providers with their quality management programs.
- The Part B ADAP Insurance Assistance Section (IAS) provided a training webinar for OA-HIPP Enrollment Workers on Medi-Cal Expansion, Covered California and how to enroll clients in OA-HIPP after Covered California enrollment. The webinar is on the OA website at www.proprofs.com/quiz-school/story.php?title=Njl5ODAyEXD3, password "OA-HIPP."
- IAS is developing two management memorandums for February release on OA-HIPP Enrollment Worker guidance.
- One is on transition of potentially eligible OA-HIPP clients into Medi-Cal Expansion. Staff will screen new applicants and current clients prior to the client's quarterly payment. Clients at <138% Federal Poverty Level (FPL) must apply to Medi-Cal Expansion or document ineligibility. OA-HIPP will send letters to potentially eligible clients on how to apply.
- The second addresses payment of family and dental policies effective 1/31/2014. The monthly maximum amount OA-HIPP will pay for total medical and/or dental insurance coverage premiums is $1,938. OA-HIPP will pay premiums for any such policy(s) that cover the client and family members (if eligible) that do not exceed the threshold.
- Mr. Fox believed OA-HIPP will pay up to the $1,938 even if total premiums exceed that amount. Mr. Rivera confirmed there are forms for partial payment on the OA website. The client pays the balance.
- ADAP also distributed a management memorandum on 2/2/2014 with guidance for Enrollment Workers on Senate Bill 249, effective 1/1/2014. It authorizes OA-HIPP contracted agencies and their Enrollment Workers to share Ryan White HIV program client data with qualified ADAP Enrollment Workers solely to facilitate enrolment in Medi-Cal Expansion or Covered California health care coverage. The memorandum is on the OA website, www.cdph.ca.gov. The law only covers Enrollment Worker employees, not volunteers, working at ADAP enrollment sites with a fully executed contract.
- OA is not applying for the new competitive FOA from the CDC PS-14-1410, Secretary's Minority AIDS Initiative Funding to Increase HIV Prevention and Care Delivery Service among Health Centers Serving High HIV Prevalence Jurisdictions. OA initiated work to apply, but was unable to secure the minimum number of clinic partners required for application.
- Ms. Kiburi noted a question was raised in December about Atripla pricing differences. ADAP will only cover the Atripla co-payment or deductible under private insurance plans.
- There was also a question on changes to the ADAP enrollment form and how it relates to the Covered California application. The ADAP application has not changed. Enrollment Workers did receive information on how to screen clients potentially eligible for Medi-Cal Expansion or Covered California using the application. Clients potentially eligible for Medi-Cal Expansion must apply. Those potentially eligible for Covered California are encouraged to apply.

- Mr. Rivera noted the Consumer Caucus had talked with Dr. Karen Mark a few months ago about the challenge presented by the requirement for a tax payer identification number on the OA-HIPP application. It was removed. That has cut two to six months off of the application process making it much easier for consumers to apply. He thanked OA.
- Ms. Kiburi said OA-HIPP was also asked if it is hiring more staff to assist clients enroll. No new staff is being hired, but OA-HIPP is training ADAP staff to assist with the transition's work load.

➲ Ms. Kiburi will follow-up on why clinics did not want to participate in the new CDC FOA.

B. California Planning Group (CPG): The last CPG applications were received and review is underway. Decisions are expected within a week. All applicants will then be notified. The goal is to seat CPG members and hold the first meeting in April.

16. STANDING COMMITTEE REPORTS:

A. Planning, Priorities and Allocations (PP&A):

1. ***FY 2014 Allocation Modifications***:

- Commissioners stated their conflicts of interest. Mr. Johnson noted they should email staff if the list omits any.
- Mr. Pérez asked about prevention portfolio conflicts. Mr. Vincent-Jones said staff just received the information. It will be added to list soon. Today's deliberations only pertain to care and treatment so the current list can be used.
- Mr. Vincent-Jones said the full model is not yet complete, but PP&A has developed a 10% cut contingency scenario which can be voted today. The former Commission approved FY 2014, 3/1/2014 to 2/28/2015, allocations in June 2013. Allocations were made with the understanding that most data was unknown, e.g., there was no data on migration to Covered California or the new Ambulatory Outpatient Medical Fee-For Services (FFS) model.
- The June motion included returning to the allocations when more information was available. PP&A has been revising and modifying allocations over the past year in chronological order. FY 2014 allocations cannot be addressed until FY 2013 expenditures are understood. FY 2013 allocations were modified in December to reflect expenditures. It was a complex year due to implementation of FFS, MCC and other variables.
- DHSP advised the Commission several months ago to anticipate cuts. Last year saw a 7% sequestration funding cut, but DHSP was able to accommodate it and avoid provider cuts. Sequestration cuts are expected again, but DHSP cannot accommodate them so PP&A was advised to address a 14% cut for FY 2014. The largest previous cut was 8%. The Federal budget has since passed and sequestration scaled back, but there is no information on how cuts will be applied though prevention was not cut. Based on that, the allocation reduction target was revised to 10%.
- The model will be fully filled out by next month including additional FY 2014 base-funding modifications. It starts with FY 2013. It delineates expenditures for all the service categories with core medical services, as defined by HRSA, which must constitute 75% of allocated Ryan White funds. The remaining 25% are supportive services.
- Mr. Land said PP&A discussed all the categories in depth. All are valuable, but retention in care are especially important now. PP&A chose to use an algorithm to cut from the six highest funded categories. Directives were discussed concurrently with the allocations and will be presented next month.
- Mr. Vincent-Jones said original allocations are done approximately a year in advance. Revised allocations are usually done in February or March and at the end of the year to ensure all funds are spent down. The Commission has given DHSP authority to move up to 10% of a service category, but it consistently consults with PP&A to assure the grant is maximized. PP&A accommodates changing expenditure estimates by adjusting allocations.
- The Commission approved revisions to the FY 2013 allocations last month based on the best expenditure estimates reflected on the financial expenditure report provided by Dave Young.
- FY 2014 allocations were first made in June by percentages and based on FY 2013 funding since FY 2014 funding is not known. The flat funding scenario assumes no change. Allocations include Part A, Part B which comes from the State on a different fiscal year, and Minority AIDS Initiative (MAI), a separate pool of funding derived from Part A with separate requirements. Separate columns reflect percentages and their dollar equivalents based on FY 2013.
- Expenditure projections are provided for FY 2014. Most are based on FY 2013, but DHSP has made commitments for larger amounts in some categories such as in MCC. Other estimates are provided if available.
- MAI is approximately $3 million allocated to Transitional Case Management, Linkage To Care and Oral Health.
- PP&A compared year-end projections for FY 2014 and allocations to date. It made some adjustments to the FY 2013 flat-funding scenario. Those allocations will be used if the same amount of funding is received in FY 2014.
- For the 10% cut scenario, PP&A chose to cut 10% from each of the six top funded categories. A small amount remained. PP&A chose to prorate that amount across the categories. The total cut is approximately $4 million.

- Flat-funding scenario allocations equal approximately $15 million. The 10% cut scenario equals approximately $13 million. Allocations are then converted back to percentages.
- Approximate 10% scenario cuts are: Medical Outpatient, $1.6 million; Oral Health, $500,000; MCC, $761,000; Mental Health, $335,000; Benefits Support, $8,000; Linkage To Care, $8,000; Transitional Case Management, $4,000; Retention In Care, $9,000; Substance Abuse, $167,000; Home-Based Care, $278,000.
- Mr. Vincent-Jones has not calculated the percentage cut, but total allocations after the cut are calculated. He will review to ensure the core medical threshold of 75% is met, but he believed it was. Mr. Land noted the base funding that formed the basis of these allocations was 90% core medical so there should be no issue.
- Mr. Ballesteros added PP&A discussed allocations in the context of funding for services through ACA and Part C
- Mr. Vincent-Jones said PP&A could calculate an increase scenario, but it was not deemed necessary. Flat-funding is considered an increase or decrease of 0% to 5%. Ranges will be included in the full model.
- There was significant discussion about medical outpatient. Considerable savings were anticipated from migration of clients to the Low Income Health Program (LIHP) and then to ACA, but savings have not been as high as expected to date. At the same time, FFS was instituted and offset any savings from migration.
- A verification model was used to review that data. Of 15,500 clients, 3,500 to 5,000 were expected to migrate to LIHP. The lower estimate seems more likely though data continues to come in. An estimated 3,500 clients in the system also appear to be Part C clients. An estimated 1,500 were expected to migrate to Covered California. That has been reduced to 750 which many still consider high. The estimate is that 7,500 clients remain in Ryan White.
- The Case Watch average of visits per client per year is 5. FFS contracts use an average of 6. He used 5.5. FFS rates are now $330 per visit, but will decline to $280 in mid-summer. The calculation varies approximately $500,000 from the financial expenditures reports. That is considered a verification of DHSP estimates.
- Mr. Smith asked about directives. Mr. Land replied they are designed to elaborate on the process, e.g., to develop more information about a category. Mr. Vincent-Jones noted directives can be to the grantee, the Commission or other bodies. They are usually presented the month following allocations. A list of directives was developed at the last meeting, but he felt PP&A needs to review, refine and prioritize them. Both the Commission and DHSP have multiple work priorities so it is important to evaluate what directives are truly important for the process.
- Mr. Ballesteros suggested withdrawing the motion since the document was not in the packet. Mr. Vincent-Jones said allocations have been made based on a presentation. Approving the motion provides the grantee information to move forward while PP&A will still have the opportunity to make adjustments based on final figures if desired.
- Mr. Smith was most interested in why PP&A cut from the highest funded categories rather than basing cuts on, e.g., utilization data and spending patterns. Mr. Johnson said it is a challenge to present this complex process to those who were not present because PP&A reviews large amounts of data, e.g., utilization data. Both the public and DHSP are well represented including Mr. Young to provide financial information. These are results of the process, but he agreed it was important to provide materials since the process is complicated and the cuts large.
- Mr. McMillin said PP&A chose to cut the largest categories after long discussion. All categories are important, e.g., there were long discussions on nutrition, food banks and oral health. The fiscal year is ending so a decision must be made, but information in a number of areas is still inadequate or missing.
- In a usual business environment, a 10% cut would be across the board. That, however, would disproportionately impact lower funded categories that might not be sustainable. Decisions will be reviewed once funding is known.

➲ Include PP&A minutes from meetings pertinent to allocations in the Commission packet.

MOTION 6: Modify the FY 2014 Ryan White Parts A/B and MAI allocations, as recommended ***(Withdrawn)***.

MOTION 7: Approve "Directives" to administrative partners, determined consequent to modification of the FY 2014 Ryan White allocations, as presented ***(Withdrawn)***.

B. Operations:

1. ***Membership Nominations***:

MOTION 8: Nominate Kevin Donnelly to the Unaffiliated Consumer, Supervisorial District 4 seat; Michael Johnson, Esq. to the Board Office 4 representative seat; and Miguel Martinez to the SPA 4 Provider representative seat, and forward the nominations to the Board of Supervisors for appointment ***(Passed as Part of the Consent Calendar)***.

2. ***Conflict of Interest Policies***:

a. ***Pol #08.3105: Federal Confict/Interest***: This policy was opened for public comment.

b. ***Pol #08.3108: State Conflict/Interest***: This policy was opened for public comment.

3. ***Pol #09.1007: Comm Member Nom/Appt***:

- Mr. Vincent-Jones noted this was opened for public comment. It was first developed when County Counsel advised that only Commission appointees could vote at formal meetings to ensure accountability for liability purposes.
- The then Standards of Care and Joint Public Policy Committees needed expertise not available on the Commission. Standards of Care sought clinician expertise and Joint Public Policy sought voting rights for the then Prevention Planning Committee members. County Counsel approved a new process that allowed appointment directly to committees following nomination. The Commission is the only County body with the process.
- The process offers committees the option to nominate members. SBP and Public Policy chose to do so. PP&A chose not to do so because of conflicts of interest issues. Operations chose not to do so because its work is primarily internal. Committees that choose to include members must define criteria according to their needs.

4. ***Pol #08.3303: Reimbursable Expenses***: This policy was opened for public comment.

C. Standards and Best Practices (SBP):

1. ***LA County Continuum of HIV Care/Services***: Dr. Younai reported the presentation was rescheduled for March.

D. Public Policy:

1. ***Commission's 2014 Policy Agenda***:

- Mr. Fox said the first section focuses on four broad priorities that respond to the changing health care system and fill remaining gaps such as routine testing, linkage to care and ensuring County services are consistent with NHAS.
- The second section provides a more specific focus on items expected to require attention in 2014. Public Policy will be tracking the items and identifying areas where the Commission can have an impact.
- Mr. Land noted OA just reported it will not apply for a CDC FOA. He urged advocacy to apply for the funds as has been successful with OA in the past. Mr. Vincent-Jones said the previous case was a unilateral OA decision. In this case, Ms. Kiburi said OA could not get partners so the Commission might be able to help with that.
- Mr. Smith asked about a role for biomedicals. Mr. Fox said there was an effort to use general statements that included options across the spectrum. Specifics can be added if desired.
- Mr. Pérez noted, as County employees, DHSP defers to the wisdom of the Board and the policy agenda they set. There were, however, a few programmatic areas he urged Public Policy to consider.
- The first pertains to concerns about how our Federal and City housing partners are approaching housing issues across the spectrum, e.g., homeless versus chronically homeless requirements. The Commission has considerable housing expertise at the table. He felt housing advocacy has not kept pace with the need.
- He noted it appears Denti-Cal will be restored, but he felt some implementation and finance issues need attention. Existing oral health partners agree. Determinations could impact the use of Ryan White resources.
- Dr. Younai asked if the Denti-Cal formulary was published for consumers. Mr. Pérez did not know, but noted Denti-Cal payment is considered payment in full. Ryan White cannot supplement it. He added Ryan White provides a more holistic set of services so there are questions about who covers what, when, why, justification and rates.
- Mr. Pérez also urged considering the evolution of health care financing and performance drivers such as financial incentives or HEDIS measures. It may be prudent to educate and advocate about the value of VL suppression as a HEDIS measure. California bears a large percentage of the national HIV burden and the County almost half of the State burden. Advocacy could call for the standard of care to target VL suppression for all systems of care.

➲ Mr. Fox will call Ms. Kiburi 2/14/2014 to discuss the CDC FOA.
➲ Add references to biomedicals, housing, Denti-Cal, a VL HEDIS measure and health plan data collection to Agenda.
➲ Withdraw motion to revise the Agenda per the discussion.

MOTION 9: Approve the Commission's 2014 Policy Agenda, as presented ***(Withdrawn)***.

2. ***Governor's 2014-2015 Budget***:

- Mr. Fox said the Governor's budget was a bit early this year. What is not in the budget is of more consequence than what is. There is no proposed expansion of OA-HIPP support to fully wrap-around all eligible out-of-pocket Covered California costs. There is no proposed restoration of the approximately $82 million in funds cut from the HIV portfolio since 2009. General Fund support is zero so there is no specific prevention or care State support.
- Those interested can access policy briefs on the Commission website which detail the 2009 cuts.
- Mr. Fox will be travelling to Sacramento next month to join in advocacy with the State Legislature regarding the two areas noted above not addressed in the budget. Advocacy will start with the OA-HIPP wrap=arounds which are essential to ensure people can move into Covered California without encuring significant out-of-picket costs that could cause them to fall out of care. HRSA has approved that use of funds and initial reception has been good.

- The California HIV Alliance will be making a General Fund ask for the first time in five years. It is likely to be approximately $25 million as a negotiation starting point. It will include funding for PEP and PrEP, syringe access, HIV testing and outreach, and linkage to care services. The targeted services are all supported by data. While the ACA will cover some of the services, not all are covered or will be affordable for everyone if they are covered.
- The ask will also include raising ADAP eligibility to 500% FPL and taking dependents into consideration. Current eligibility requirements only consider the individual's income regardless of dependents.
- The Alliance will also add its voice to advocacy for the rollback of the AB 97 10% Medi-Cal cuts to providers.
- Mr. Fox will forward the Alliance's policy agenda to the Commission once it is available. He is its Co-Chair.

3. ***City of LA Ballot Initiative: Creation of Los Angeles City Health Commission***:

- Mr. Fox said the Committee was uncertain of the initiative's purpose. It could intersect with Commission work so the authors were invited to present their thinking. The City discussed its view at the Annual Meeting.
- A court ruled against the previous initiative to create a City health department so that will not be on the ballot.

17. CITY/HEALTH DISTRICT REPORTS:

A. City of Long Beach:

- Dr. Kushner, Health Officer, Department of Health and Human Services, City of Long Beach, noted Long Beach is one of three major city health department jurisdictions in the State. The other two are Pasadena and Berkeley.
- Long Beach currently has a population of 480,000. Approximately 41% are Latino, mostly Mexican-American; 29% white; 13% African-American; and almost 13% Asian, mostly Cambodian and Filipino.
- Of 61 State health jurisdictions, Long Beach is in the top eight for cumulative HIV cases and the top six for cumulative AIDS cases. It has tracked AIDS since its first case in 1983. Approximately 87% of HIV and 92% of AIDS cases are male. The major exposure category is MSM. There are currently over 3,000 AIDS cases and close to 1,500 non-AIDS HIV cases.
- Long Beach offers a full range of prevention services. The HIV Prevention Planning Committee includes all the Long Beach testing partners and agencies. It meets regularly at the Health Department.
- Long Beach performs approximately 10,000 HIV tests annually and works to increase numbers. A major Long Beach hospital plans to start emergency room testing soon. He supports the recommendation for health plan routine testing.
- St. Mary's Care Clinic is the largest HIV provider with over 1,200 unduplicated patients. Long Beach DHHS has had an HIV clinic since 1988 and has 270 unduplicated patients. Other sites are: Tom K. Long Beach Comprehensive Center affiliated with Harbor-UCLA Hospital, 200 unduplicated patients; multiple private providers including two Health Care Partners sites, 400 patients; Long Beach Memorial clinic, approximately 20 pediatric patients and their HIV+ family members; AIDS Healthcare Foundation, a new two day a week clinic at their Out Of the Closet site.
- Long Beach also has a significant STI caseload. The syphilis incidence rate is 10.1/100,000 which is higher than both Los Angeles County and California. It is highest among white and African-American males, predominantly HIV+ males.
- The chlamydia incidence is also high and higher than that in the County and the State at 518/100,000.
- The gonorrhea case load at approximately 440 cases is a little lower than that of the County and the State. It is predominately among African-American men and women with most cases located in two geographic areas. Transmission is predominantly heterosexual sexual activity.
- DHHS is conducting a PrEP study with Harbor-UCLA, USC and UC-San Diego. Some 30 people have enrolled to date.
- The ACA rollout has been very painful. He has been speaking with health plans since October, but still has not contract. Approximately 80 HWLA patients have been referred to LA Care and Health Net so DHHS has had to refer them to other providers to maintain care. The LA Care contract process is further along than that for Health Net.
- The rest of the DHHS HIV clinic patients are covered with Ryan White, Medi-Medi or other carriers.

B. City of Los Angeles:

- Mr. Rosales reported the AIDS Coordinator's Office was established in 1989 by then Mayor Thomas Bradley. Originally it addressed issues related to the AIDS diagnoses of City employees such as discrimination and stigma. The first work of the Office was to develop an HIV policy for the City. It rolled out in 1991 and was updated in 2008.
- The Office has expanded over time to address more policy, advocacy and funding programs. Administrative work includes policy planning, a technical assistance program and a small annual research project.
- Program work includes education and prevention. The City reviews County efforts and funds missing pieces that enhance or develop a piece of a program that will lead to better health outcomes, programming or innovation.

- Annual funding is approximately $1 million for 18 contracts. Traditionally, half of funds go to syringe exchange since the City was the only entity doing it. The City has been working with the County for the last five years to expand services. The other half funds Health Education/Risk Reduction targeting populations that need more or better services.
- The City is fully funded by the HUD community block grant. It applies each Fall. This year it anticipated a maximum 5% budget cut due to sequestration and other budget matters. The Office has not yet received its allocation, but did receive a communication from HUD in January that the definition of public services was being changed.
- The community block grant is considered public services. There had been two pools of that funding: one for services on the street and the other services such as those provided by the Office. Now both will compete for the same funds. Mr. Rosales has been meeting with Council offices and the Mayor's Office to ensure the Office was not forgotten.
- Yesterday the City released its plan. It moves the Office's programs out of the public services funding stream entirely and to general funds for the first time. That will allow more flexibility and innovation.
- The down side is that general funds are not stable. The City has had budget problems for years. In the short term, only 52% of the Office's current prevention services budget has been identified in general funds, i.e., a 42% budget cut. Mr. Rosales met until 7:00 pm the previous night with the Mayor and Council Offices to identify options.
- The administrative side of the budget was not touched. The Office is in the process of hiring a new staff person.
- The Office's current research project is an assessment and update of the Office's operating framework. A contractor is assisting with the project and has already conducted some interviews. A roundtable hosted by the Mayor's Office will offer additional feedback on where they should be in the next 5 to 10 years.
- The next project will focus on economic empowerment by reviewing Los Angeles business hiring, retention and training practices pertaining to the transgender community. Transgender individuals are at increased risk of acquiring HIV due to the lack of job opportunities. The Office plans to develop a model, e.g., training for businesses and the community.
- Mr. Land recommended advocating for the Office's resources if possible. Mr. Vincent-Jones said non-Ryan White funds are used for Commission advocacy activities so it may advocate as it sees fit. Mr. Pérez suggested an offline discussion.

➲ Refer advocacy on behalf of City AIDS Coordinator's Office funding to Executive Committee and Caucuses.

C. City of Pasadena:

- Ms. Palmeros, Public Health Department, reported approximately 50% of the population is Caucasian. The remainder is diverse with Latinos, African-Americans, Asians and a growing senior population.
- Human Services is separate, but embedded in the Recreation Department. The Housing Department is also separate, but the departments all collaborate. Pasadena also works closely with Altadena and the surrounding cities.
- The Council directed implementation of an HIV Task Force in 1990. The Department of Public Health began prevention efforts and to create systems of care. The AIDS Service Center developed out of that effort.
- City HIV services were recently reorganized due to health care landscape changes and funding cuts. Consequently, AIDS Service Center delegated its contracts to the Public Health Department which developed a medical home model with co-located services. A mobile unit also offers prevention services especially for Spanish-speaking communities in the North West. The Department has partnered with APLA to address food issues in that area.
- The City recently received a HRSA grant to address adherence and care issues among homeless PLWH. Retention and engagement models are being reviewed with special attention to substance abuse and mental health issues. A peer model has been initiated in close collaboration with the Housing Department.
- A new SAMHSA grant to research systems of care for youth and behavioral issues is being used to study the impact of early age LGBTQ issues on development by working with parents and focus groups. The City is collaborating with the Pasadena Unified School District, Altadena and Sierra Madre. The phased grant should allow expanded collaboration.
- Public Health Department HIV services do not receive City general funds, but leverage DHSP and other grant funding.
- The transition of clients through HWLA highlighted benefits issues. Enrollment workers are now trained to address both ADAP and ACA. Homeless peer workers have also been certified as ACA enrollment workers and innovative approaches are being explored to reach clients where they are, e.g., by using iPads.
- Some clients have had to transition into other systems creating engagement problems especially for clients with substance abuse or mental health issues. The City's MCC program is working to assist these clients stay in care.
- The Public Health Department is also contracting with other insurance programs to offer more specialized care.
- Hiring is underway for an infectious disease doctor to expand STD programs especially among youth and their parents.
- The State uses Parole and Community Team (PACT) meetings to help parolees to transition to life beyond incarceration. The City and community-based organizations have started their own monthly meetings. The Public Health Department is using the PACT meetings to engage parolees who are HIV+ in HIV services.

- The Public Health Department is working with DHSP to increase HIV oral health services. There are now 320 patients.
- The home health program is also being reviewed to increase evidence-based services for the senior population.
- The Public Health Department dedicated the Bradley G. Land Waiting Room in recognition of Mr. Land's public service.

B. City of West Hollywood:

- Mr. Giugni, Social Services Division, noted the City, incorporated in 1984, is just 1.9 square miles between Hollywood and Beverly Hills. The population of approximately 37,000 is 40% LGBT. It includes a high rate of seniors and is just under 80% Caucasian with Russian immigrants the largest ethnic population.
- The HIV/AIDS epidemic in the City continues to be an one of MSM with 98% of transmissions in that population.
- The City does not have its own health department. It is a contract city which contracts its social services including those for HIV/AIDS prevention and care. The City's first social services grant was to LAGLC for HIV prevention and care. Social services grants now total approximately $4.2 million annually. Approximately a third funds HIV/AIDS prevention and care and related services with more now going to treatment and housing-related services.
- The new three-year contract cycle has just started. The City contracts from its general fund of tax dollars to serve residents. Contracts provide services for residents, who are defined as those who live, reside, work, attend school, own property or are homeless and spend a majority of his or her time in the City of West Hollywood.
- The City conducted an in-depth community needs assessment to identify priorities and gaps prior to its recent contracting cycle. HIV/AIDS care remains a high priority in addition to substance abuse treatment and transgender community services. Consequently, the City included those priorities in its RFP.
- It has entered into contracts with five new programs including Tarzana Treatment Center and the Substance Abuse Foundation of Long Beach. Contracts have added much needed treatment beds.
- It has also added housing services tied to services for the most fragile homeless community members. A few years prior the City received 20 Shelter+Care housing certificates for those with mental health co-occurring with substance abuse diagnoses. The City has now contracted with Housing Works to provide case management for those clients.
- The City's Social Services Division has also developed its own HIV/substance abuse prevention social marketing campaigns since 2004 when DHSP funding ended. Funds are in addition to the $4.2 million in contracted services.
- The City's Housing Department contracts with the West Hollywood Community Housing Corporation to develop and provide low-income housing for seniors and those with disabilities. A few buildings specifically provide housing for low-income PLWH, e.g., the Harper Community. New units continue to come online and populations served have expanded to include low-income people with HIV, other disabilities and now youth at the Courtyard at La Brea in development.

19. CAUCUS REPORTS:

A. Consumer Caucus:

- Mr. Liso reported LA Care met with the Caucus to discuss their challenges and encourage input on ways to help maintain people in care. Call the LA Care warm line, 888.839.9909, for questions or complaints.
- The next Consumer Caucus will follow the 3/13/2014 Commission meeting.

1. ***Policy/Procedure #09.7201: Consumer Compensation***:

- Mr. Liso noted the policy/procedure was open for public comment until 2/28/2014.
- Ms. Tula asked about delays in implementation and if compensation will be retroactive. Mr. Vincent-Jones replied, as the Caucus was previously advised, the policy would take three to six months to implement and there will not be retroactive reimbursement. The timeline is on track for a possible start in one month with payment quarterly.
- The Commission and Executive Office are determining how to reimburse funds and how to bill the Executive Office including form development. The process must be consistent with the Commission's budget. It is also necessary to identify how many people will request vouchers versus cash payments since that affects viability of the program.
- Mr. Zaldivar asked what stipends were for, their amount and whether they were required by funding.
- Mr. Vincent-Jones replied stipends are not required. The Commission has worked for nearly three years to obtain permission to offer them. They are targeted to a class of commissioners who are very low income and for whom being a commissioner entails a burden on finances and resources, e.g., for transportation or to purchase lunch. Stipends are a way to compensate for those costs, to recognize commissioners' work and enable full participation.
- Ryan White does not allow that use of its funds and it was originally the sole source of Commission funding. Stipends were reconsidered when the Commission and DHSP agreed that the Commission could use a small amount of Net County Cost funds for things not funded by Ryan White.

- Many County commissions receive stipends, but in a different way, e.g., they pay for the main meeting, but not for committee meetings which are central to how the Commission works. The Commission also wanted standards for performance which was a new concept for the County. The many differences made for a long and laborious aspect of the Commission integration process. Stipends were eventually included in the Ordinance.
- Commission financial matters go through the Executive Office so the billing process is now being developed. Stipends are $100 per month for unaffiliated consumer members and $50 per month for alternates. Recipients must attend two to three meetings per month, be a commissioner in good standing and fill out some invoice paperwork. Those for whom cash payments would constitute a threat to benefits may request vouchers instead.
- An "unaffiliated consumer" is someone who uses Ryan White services and is, by definition, low income. The process began long before unification. Mr. Vincent-Jones was not opposed to including prevention consumers, but was opposed to staff doing financial eligibility screening. There were many discussions on how to define a "prevention consumer" during unification and afterwards. Despite progress, no clear definition was developed. Diane Burbie, The Aspire Group, recommended returning to the discussion in a few months. That is planned.

B. Latino Caucus:

- Mr. Vincent-Jones reported Co-Chairs Sergio Avińa and Dr. Espinoza as well as some other key people have had scheduling issues. The main problem, however, is recruiting a sufficient number of regular members. He has suggested quarterly meetings might help. He and Dr. Espinoza were meeting the next week to address the issue.
- ➲ Mr. Zaldivar offered to help develop the Latino Caucus.

C. Transgender Caucus: There was no report.

20. **TASK FORCE REPORTS**: Ms. Rotenberg announced the SPA 4 network meeting will be 2/20/2014, 12:00 noon, APLA, 3743 South La Brea. Contact her for more information at JWCH, 213.484.1186.

21. AIDS EDUCATION/TRAINING CENTERS (AETC): There was no report.

22. **SPA/DISTRICT REPORTS**: There was no report.

23. **COMMISSION COMMENT:** There were no comments.

24. ANNOUNCEMENTS:

- Ms. Rotenberg announced the monthly HIV Women's Task Force meeting will be 2/24/2014, 9:30 am, APLA on Kingsley. The newly formed CAB will be preparing for this summer's HIV Women's Summit.
- Ms. Enfield announced the Red Circle Project's 4th Annual Celebrating All Life and Creation Pow Wow will be 6/28/2014, Plummer Park, 10:00 am to 6:00 pm. Past events have drawn approximately 500 attendees with many people tested for HIV and screened for STDs. Agencies that would like a table at the even should email her.

25. ADJOURNMENT: The meeting adjourned at 4:00 pm in memory of Michelle Branch. Mr. Johnson also adjourned the meeting in memory of his friend from Long Beach, "Sir Charles." He did not want anyone to know he was HIV+ and was lost in addiction. He represents one of the many lost to care and isolated. He died in his home and lay undiscovered for two weeks. Mr. Johnson urged everyone to do more to address how substance abuse impacts HIV and remember all those we are not reaching today.

A. Roll Call (**Present)**: Ballesteros, Enfield, Ferlito, Forrest, Garbutt, Giugni, Goddard, Green, Johnson/Donnelly, Kelly, Kochems, Kushner, Land, Lawson, Liso/Lantis, Lopez, McMillin, Morales, Munoz, Palmeros, Pérez, Rios, Rivera/Escoto, Rosales, Rotenberg, Sanjurjo, Smith, Younai, Zaldivar

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order with Motion 7 withdrawn.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve, and revise as necessary, the minutes from the April 11, 2013 Joint Commission on HIV/Prevention Planning Committee (PPC) meeting, the October 10, 2013 and December 12, 2013 Commission on HIV meetings, and the November 14, 2013 Commission on HIV Annual Meeting, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve the Consent Calendar with Motions 5, 6 and 9 pulled for discussion.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Ratify the December 12, 2013 election of Commissioner Juan Rivera as the Commission's representative to the California Planning Group (CPG) for the State Office of AIDS (OA).	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 5: Select a new Commission on HIV logo and variations from among those presented.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 5A: ***(Zaldivar/Land)*****:** Refer process of selecting a logo to the Operations Committee for further action.	***Passed by Consensus***	**MOTION PASSED**
MOTION 6: Modify the FY 2014 Ryan White Parts A/B and MAI allocations, as recommended.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 7: Approve "Directives" to administrative partners, determined consequent to modification of the FY 2014 Ryan White allocations, as presented.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 8: Nominate Kevin Donnelly to the Unaffiliated Consumer, Supervisorial District 4 seat; Michael Johnson, Esq. to the Board Office 4 representative seat; and Miguel Martinez to the SPA 4 Provider representative seat, and forward the nominations to the Board of Supervisors for appointment.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 9: Approve the Commission's 2014 Policy Agenda, as presented.	***Withdrawn***	**MOTION WITHDRAWN**